

106TH CONGRESS
1ST SESSION

H. R. 1806

To amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to require that group and individual health insurance coverage and group health plans provide adequate access to providers of obstetric and gynecological services.

IN THE HOUSE OF REPRESENTATIVES

MAY 13, 1999

Mrs. LOWEY (for herself and Mr. LAZIO) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committees on Education and the Workforce, and Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to require that group and individual health insurance coverage and group health plans provide adequate access to providers of obstetric and gynecological services.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE; FINDINGS.**

2 (a) SHORT TITLE.—This Act may be cited as the
3 “Access to Women’s Health Care Act of 1999”.

4 (b) FINDINGS.—Congress finds the following:

5 (1) Women’s health historically has received lit-
6 tle attention.

7 (2) Women have a different set of primary care
8 needs than men and providing direct access to pro-
9 viders of obstetric and gynecological services is an
10 important way to address some of these differences.

11 (3) A majority of women view their provider of
12 obstetric and gynecological services as their primary
13 or sole care provider.

14 (4) 78 percent of women think direct access to
15 providers of obstetric and gynecological services is
16 very important.

17 (5) Access to obstetric and gynecological serv-
18 ices improves the health of a woman by providing
19 primary and preventive health care throughout the
20 woman’s lifetime, encompassing care of the whole
21 patient in addition to focusing on the processes of
22 the female reproductive system.

23 (6) More than 60 percent of all office visits to
24 providers of obstetric and gynecological services are
25 for preventive care.

1 (7) President Clinton’s Advisory Commission on
2 Consumer Protection and Quality in the Health
3 Care Industry recommended that women should be
4 able to choose a qualified provider, including obstre-
5 trician-gynecologists, certified nurse midwives, and
6 other qualified care providers offered by a plan, for
7 the provision of routine and preventive women’s
8 health care services.

9 (8) Providers of obstetric and gynecological
10 services refer their patients to other health care pro-
11 fessionals less frequently than other primary care
12 providers, thus avoiding costly and time-consuming
13 referrals.

14 (9) Providers of obstetric and gynecological
15 services manage the health of women beyond the re-
16 productive system, and are uniquely qualified on the
17 basis of education and experience to provide basic
18 health care services to women.

19 (10) While more than 37 States have acted to
20 promote residents’ access to providers of obstetric
21 and gynecological services, patients in other States
22 or in Federally-governed health plans are not pro-
23 tected from access restrictions or limitations.

1 **SEC. 2. PATIENT ACCESS TO UNRESTRICTED OBSTETRIC**
2 **AND GYNECOLOGICAL SERVICES..**

3 (a) PUBLIC HEALTH SERVICE ACT AMENDMENTS.—

4 (1) GROUP HEALTH INSURANCE COVERAGE.—

5 Subpart 2 of part A of title XXVII of the Public
6 Health Service Act is amended by adding at the end
7 the following new section:

8 **“SEC. 2707. STANDARDS RELATING TO ACCESS TO UNRE-**
9 **STRICTED OBSTETRIC AND GYNECOLOGICAL**
10 **SERVICES.**

11 “(a) IN GENERAL.—In a case in which a group
12 health plan or health insurance issuer offering health in-
13 surance coverage in connection with a group health plan
14 provides benefits under the terms of the plan consisting
15 of obstetric or gynecological services, including appro-
16 priate follow-up services and referrals for related obstetric
17 or gynecological services, the plan or issuer shall provide
18 for a female participant or beneficiary to designate a pro-
19 vider of obstetric and gynecological services who has
20 agreed to be designated as such, as the participant or
21 beneficiary’s primary care provider. If such participant or
22 beneficiary has not designated such a provider as a pri-
23 mary care provider, the plan or issuer—

24 “(1) may not require prior authorization by the
25 participant or beneficiary’s primary care provider or
26 otherwise for coverage of obstetric or gynecological

1 services provided by a participating health care pro-
2 fessional practicing in accordance with State law, to
3 the extent such care is otherwise covered; and

4 “(2) shall treat the ordering of other gynecological services by such a participating health care
5 professional as the prior authorization of the pri-
6 mary care provider with respect to such care under
7 the coverage.

8
9 “(b) ADEQUATE NUMBER OF PROVIDERS OF OB-
10 STETRIC AND GYNECOLOGICAL SERVICES.—Each group
11 health plan and health insurance issuer offering health in-
12 surance coverage in connection with a group health plan
13 shall have an adequate number of providers of obstetric
14 and gynecological services on its roster to satisfy the
15 health care needs of all female participants and bene-
16 ficiaries who choose to have such a provider as a primary
17 care provider, or who otherwise need the services of a pro-
18 vider of obstetric and gynecological services.

19 “(c) DEFINITION OF “PROVIDER OF OBSTETRIC AND
20 GYNECOLOGICAL SERVICES”.—For purposes of this sec-
21 tion the term “provider of obstetric and gynecological serv-
22 ices means—

23 “(1) an obstetrician-gynecologist;

24 “(2) a nurse practitioner as defined in section
25 1861(aa)(5)(A); or

1 “(3) a certified nurse-midwife as defined in sec-
2 tion 1861(gg)(2).

3 “(d) CONSTRUCTION.—Nothing in subsection (a)(2)
4 shall waive any requirements of coverage relating to med-
5 ical necessity or appropriateness with respect to coverage
6 of obstetric or gynecological services so ordered.

7 “(e) PROHIBITIONS.—A group health plan, and a
8 health insurance issuer offering group health insurance
9 coverage in connection with a group health plan, may
10 not—

11 “(1) deny to a woman eligibility, or continued
12 eligibility, to enroll or to renew coverage under the
13 terms of the plan, solely for the purpose of avoiding
14 the requirements of this section;

15 “(2) provide monetary payments or rebates to
16 women to encourage such women to accept less than
17 the minimum protections available under this sec-
18 tion; or

19 “(3) penalize or otherwise reduce or limit the
20 reimbursement of a provider because such provider
21 provided care to an individual participant or bene-
22 ficiary in accordance with this section.

23 “(f) LEVEL AND TYPE OF REIMBURSEMENTS.—
24 Nothing in this section shall be construed to prevent a
25 group health plan or a health insurance issuer offering

1 group health insurance coverage from negotiating the level
2 and type of reimbursement with a provider for care pro-
3 vided in accordance with this section.

4 “(g) NON-PREEMPTION OF MORE PROTECTIVE
5 STATE LAW WITH RESPECT TO HEALTH INSURANCE
6 ISSUERS.—This section shall not be construed to super-
7 sede any provision of State law which establishes, imple-
8 ments, or continues in effect any standard or requirement
9 solely relating to health insurance issuers in connection
10 with group health insurance coverage that provides great-
11 er protections to participant and beneficiaries than the
12 protections provided under this section.”.

13 “(h) NOTICE.—A group health plan under this part
14 shall comply with the notice requirement under section
15 714(b) of the Employee Retirement Income Security Act
16 of 1974 with respect to the requirements of this section
17 as if such section applied to such plan.”.

18 (2) INDIVIDUAL HEALTH INSURANCE COV-
19 ERAGE.—Part B of title XXVII of such Act is
20 amended by inserting after section 2752 the fol-
21 lowing new section:

1 **“SEC. 2753. STANDARDS RELATING TO ACCESS TO UNRE-**
 2 **STRICTED OBSTETRIC AND GYNECOLOGICAL**
 3 **SERVICES.**

4 “(a) IN GENERAL.—The provisions of section 2707
 5 shall apply to health insurance coverage offered by a
 6 health insurance issuer in the individual market in the
 7 same manner as it applies to health insurance coverage
 8 offered by a health insurance issuer in connection with a
 9 group health plan in the small or large group market.

10 “(b) NOTICE.—A health insurance issuer under this
 11 part shall comply with the notice requirement under sec-
 12 tion 714(b) of the Employee Retirement Income Security
 13 Act of 1974 with respect to the requirements referred to
 14 in this section as if such section applied to such issuer
 15 and such issuer were a group health plan.”.

16 (b) ERISA AMENDMENTS.—

17 (1) IN GENERAL.—Subpart B of part 7 of sub-
 18 title B of title I of the Employee Retirement Income
 19 Security Act of 1974 is amended by adding at the
 20 end the following new section:

21 **“SEC. 714. STANDARDS RELATING TO ACCESS TO UNRE-**
 22 **STRICTED OBSTETRIC AND GYNECOLOGICAL**
 23 **SERVICES.**

24 “(a) IN GENERAL.—A group health plan (and a
 25 health insurance issuer offering group health insurance
 26 coverage in connection with such a plan) shall comply with

1 the requirements of section 2707 of the Public Health
2 Service Act.

3 “(b) NOTICE UNDER GROUP HEALTH PLAN.—The
4 imposition of the requirement of this section shall be treat-
5 ed as a material modification in the terms of the plan de-
6 scribed in section 102(a)(1), for purposes of assuring no-
7 tice of such requirements under the plan; except that the
8 summary description required to be provided under the
9 last sentence of section 104(b)(1) with respect to such
10 modification shall be provided by not later than 60 days
11 after the first day of the first plan year in which such
12 requirement apply.”.

13 (2) CONFORMING AMENDMENT.—Section
14 732(a) of such Act (29 U.S.C. 1191a(a)) is amended
15 by striking “section 711” and inserting “sections
16 711 and 714”.

17 (3) CLERICAL AMENDMENT.—The table of con-
18 tents in section 1 of such Act is amended by insert-
19 ing after the item relating to section 713 the fol-
20 lowing new item:

“Sec. 714. Standards relating to access to unrestricted obstetric and gynecological services.”.

21 (c) INTERNAL REVENUE CODE AMENDMENTS.—

22 (1) IN GENERAL.—Subchapter B of chapter
23 100 of the Internal Revenue Code of 1986 is amend-

1 ed by inserting after section 9812 the following new
2 section:

3 **“SEC. 9813. STANDARDS RELATING TO ACCESS TO UNRE-**
4 **STRICTED OBSTETRIC AND GYNECOLOGICAL**
5 **SERVICES.**

6 “(a) IN GENERAL.—In a case in which a group
7 health plan provides benefits under the terms of the plan
8 consisting of obstetric or gynecological services, including
9 appropriate follow-up services and referrals for diagnostic
10 testing related to obstetric or gynecological services, the
11 plan shall provide for a female participant or beneficiary
12 to designate a provider of obstetric and gynecological serv-
13 ices who has agreed to be designated as such, as the par-
14 ticipant or beneficiary’s primary care provider. If such
15 participant or beneficiary has not designated such a pro-
16 vider as a primary care provider, the plan—

17 “(1) may not require prior authorization by the
18 participant or beneficiary’s primary care provider or
19 otherwise for coverage of obstetric or gynecological
20 services provided by a participating health care pro-
21 fessional practicing in accordance with State law, to
22 the extent such service is otherwise covered; and

23 “(2) shall treat the ordering of other gynecological
24 services by such a participating health care
25 professional as the prior authorization of the pri-

1 mary care provider with respect to such care under
2 the coverage.

3 “(b) ADEQUATE NUMBER OF PROVIDERS OF OB-
4 STETRIC AND GYNECOLOGICAL SERVICES.—Each group
5 health plan shall have an adequate number of providers
6 of obstetric and gynecological services on its roster to sat-
7 isfy the health care needs of all female participants and
8 beneficiaries who choose to have such a provider as a pri-
9 mary care provider, or who otherwise need the services of
10 a provider obstetric and gynecological services.

11 “(c) DEFINITION OF “PROVIDER OF OBSTETRIC AND
12 GYNECOLOGICAL SERVICES”.—For purposes of this sec-
13 tion the term “provider of obstetric and gynecological serv-
14 ices means—

15 “(1) an obstetrician-gynecologist;

16 “(2) a nurse practitioner as defined in section
17 1861(aa)(5)(A) of the Social Security Act (42
18 U.S.C. 1395x(aa)(5(A)); or

19 “(3) a certified nurse-midwife as defined in sec-
20 tion 1861(gg)(2) of the Social Security Act (42
21 U.S.C. 1395x(gg)(2)).

22 “(d) CONSTRUCTION.—Nothing in subsection (a)(2)
23 shall waive any requirements of coverage relating to med-
24 ical necessity or appropriateness with respect to coverage
25 of obstetric or gynecological services so ordered.

1 “(e) PROHIBITIONS.—A group health plan, and a
2 health insurance issuer offering group health insurance
3 coverage in connection with a group health plan, may
4 not—

5 “(1) deny to a woman eligibility, or continued
6 eligibility, to enroll or to renew coverage under the
7 terms of the plan, solely for the purpose of avoiding
8 the requirements of this section;

9 “(2) provide monetary payments or rebates to
10 women to encourage such women to accept less than
11 the minimum protections available under this sec-
12 tion; or

13 “(3) penalize or otherwise reduce or limit the
14 reimbursement of a provider because such provider
15 provided care to an individual participant or bene-
16 ficiary in accordance with this section.

17 “(f) LEVEL AND TYPE OF REIMBURSEMENTS.—
18 Nothing in this section shall be construed to prevent a
19 group health plan from negotiating the level and type of
20 reimbursement with a provider for care provided in ac-
21 cordance with this section.”.

22 (2) CONFORMING AMENDMENT.—Section
23 4980D(d)(1) of such Code is amended by striking
24 “section 9811” and inserting “sections 9811 and
25 9813”.

1 (3) CLERICAL AMENDMENT.—The table of sec-
2 tions of subchapter B of chapter 100 of such Code
3 is amended by inserting after the item relating to
4 section 9812 the following new item:

 “Sec. 9813. Standards relating to access to unrestricted obstetric
 and gynecological services.”.

5 (d) EFFECTIVE DATES AND RELATED RULES.—

6 (1) GROUP HEALTH PLANS AND GROUP
7 HEALTH INSURANCE COVERAGE.—

8 (A) IN GENERAL.—Subject to subpara-
9 graph (B), the amendments made by sub-
10 sections (a)(1), (b), and (c) apply with respect
11 to group health plans for plan years beginning
12 on or after the first day of the first month that
13 begins more than 1 year after the date of the
14 enactment of this Act.

15 (B) COLLECTIVE BARGAINING EXCEP-
16 TION.—In the case of a group health plan
17 maintained pursuant to 1 or more collective
18 bargaining agreements between employee rep-
19 resentatives and 1 or more employers ratified
20 before the date of enactment of this Act, the
21 amendments made subsections (a)(1), (b), and
22 (c) shall not apply to plan years beginning be-
23 fore the later of—

1 (i) the date on which the last collec-
2 tive bargaining agreements relating to the
3 plan terminates (determined without re-
4 gard to any extension thereof agreed to
5 after the date of enactment of this Act), or
6 (ii) the first day described in subpara-
7 graph (A).

8 For purposes of clause (i), any plan amendment
9 made pursuant to a collective bargaining agree-
10 ment relating to the plan which amends the
11 plan solely to conform to any requirement
12 added by subsection (a)(1), (b), or (c) shall not
13 be treated as a termination of such collective
14 bargaining agreement.

15 (2) INDIVIDUAL HEALTH INSURANCE COV-
16 ERAGE.—The amendment made by subsection (a)(2)
17 applies with respect to health insurance coverage of-
18 fered, sold, issued, renewed, in effect, or operated in
19 the individual market on or after the first day of the
20 first month that begins more than 1 year after the
21 date of the enactment of this Act.

22 (3) LIMITATION ON ENFORCEMENT ACTIONS.—
23 No enforcement action shall be taken, pursuant to
24 the amendments made by this section, against a
25 group health plan or health insurance issuer with re-

1 spect to a violation of a requirement imposed by
2 such amendments, and no penalty shall be imposed
3 on any failure by such plan to comply with any re-
4 quirement imposed by such amendments, to the ex-
5 tent that violation or failure occurs before the date
6 of issuance of final regulations issued in connection
7 with such requirement, if the plan or issuer has
8 sought to comply in good faith with such require-
9 ment.

10 **SEC. 3. COORDINATION OF ADMINISTRATION.**

11 The Secretary of Labor, the Secretary of the Treas-
12 ury, and the Secretary of Health and Human Services
13 shall ensure, through the execution of an interagency
14 memorandum of understanding among such Secretaries,
15 that—

16 (1) regulations, rulings, and interpretations
17 issued by such Secretaries relating to the same mat-
18 ter over which two or more such Secretaries have re-
19 sponsibility under the provisions of this Act (and the
20 amendments made thereby) are administered so as
21 to have the same effect at all times; and

22 (2) coordination of policies relating to enforcing
23 the same requirements through such Secretaries in
24 order to have a coordinated enforcement strategy

- 1 that avoids duplication of enforcement efforts and
- 2 assigns priorities in enforcement.

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